

## **General Information for Authorization**

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Org 1. 5	505					Serv	ісе Туре	2. HSPC	
					Client Ir	nforma	ition		
Name 3. CLIENT NAME				Clie	nt ID	4. 123456789WA			
Living Arrangements 5.				Refe	erence Auth#	6.			
	-	-			Provider	Inform	ation		
Requesting	NPI#	7. 1123456	3456789			Req	uesting Fax#	8. XXXXXXXXXX	
Servicing N	1PI #	9, 1123456	1123456789			Nam	ne	10. SERVICING PROVIDER NAME	
Referring N	IPI#	11, 1123450	5789			Refe	erring Fax #	12. XXXXXXXXX	
Service Sta				•				14. N/A	
	لل			Se	rvice Requ	est In	formation		
Description of service being requested: 15. specific Hospice services requested						16.	N/A	17. N/A	
	NEA# N/A	T	1			19.	N/A 1		00 T#
20. Code Qualifier	21. National Code			24, \$ Am Reques			26. Tooth or Quad #		
R	Revenue Co			N/A	A N/A		N/A	N/A	
									-
					· · · · · · · · · · · · · · · · · · ·				
	<u> </u>		·		Medical	Inform	ation		·
Diagnosis	Code	27. I	CD-9	Diagnosi	s name	28.			
Place of service 29. 12						disease and the second			
30. Commo	ents: OTHE	R POS COU	ILD IN	CLUDE 21	OR 31 O	R 34			

## www.WaProviderOne.org

The material in this facsimile transmission is intended only for the use of the individual to who it is addressed and may contain information that is confidential, privileged, and exempt from disclosure under applicable law. <u>HIPAA Compliance</u>: Unless otherwise authorized in writing by the patient, protected health information will only be used to provide treatment, to see insurance payment, or to perform other specific health care operations.

## Instructions to fill out the General Information for Authorization form, DSHS 13-835

FIELD	NAME		ALL FIELDS MUST BE TYPED.						
	Org required	Enter th	ne Number that Matches the Progra	am/Unit fo	or the Request				
1		501 - D 502 - D 509 - E 504 - H 505 - H 506 - In 507 - Ju 508 - M 510 - M 511 - O 513 - Pl 514 - A	500 - Division of Alcohol and Substance Abuse (DASA) 501 - Dental 502 - Durable Medical Equipment (DME) 509 - Economic Services Administration (ESA) (DSHS) 504 - Home Health 505 - Hospice 506 - Inpatient Hospital 507 - Juvenile Rehabilitation Administration (JRA) (DSHS) 508 - Medical 509 - Medical Nutrition 510 - Mental Health 511 - Outpt Proc/Diag 513 - Physical Medicine & Rehabilitation (PM & R) 514 - Aging and Disability Services Administration (ADSA) 515 - Transportation 516 - Miscellaneous						
	Service Type required	Enter th	e letter(s) in all CAPS that represe	ent the ser	vice type you are requesting.				
	Colvino Typo required	AA BB	Ambulatory Aids  Bath Bench	OS OTC	Orthopedic Shoes Orthotics				
		BEM	Bath Equipment (misc)	PAS	PAS				
		BGM	Blood Glucose Monitors	PDN					
		BGS	Bone Growth Stimulator		Duty Nursing				
		BP	Breast Pumps	PHY	Pharmacy				
		BS	Bariatric surgery	PL.	Patient Lifts				
		BSS2	Bariatric surgery stage 2	PMR	PM and R				
		C	Commode	PROS	Prosthetics				
		CI	Cochlear Implants	PRS	Prone Standers				
		CIERP		PSY	Psychotherapy				
		csc	Commode/Shower Chair	PTL	Partial				
		CWN	Crowns	PWH	Power Wheelchair - Home				
		DASA	DASA	PWNF					
		DEN	Dentures	PWNF					
		EN	Enteral Nutrition	PHYS	Physician Services				
2		ESA	ESA	R	Respiratory				
2		FSFS	Floor Sitter/Feeder Seat	RB\$	Rebases				
		HB	Hospital Beds	RE	Room equipment				
		HEA	Hearing Aids	RLNS	Relines				
		HH	Home Health	RM S	Readmission				
		HSPC	Hospice Infusion/Parental Therapy	SBS	Surgery				
		IPT ITA	Inpatient admission - ITA	SC	Specialty Beds/Surfaces Shower chairs				
		JRA	JRA	SCAN	MRI/PET Scans				
		LTAC	LTAC	SF	Standing Frames				
		MC	Medication	SGD	Speech Generating Device				
		MISC	Miscellaneous	SSIP	Short Stay (In-Patient)				
		MN	Medical Nutrition	JOIP T	Therapies (PT/OT/ST)				
		MWH	Manual Wheelchair - Home	TRN	Transportation				
		MWNF	Manual Wheelchair - NF	TU	TENS Units				
		O	Other	US	Urinary Supplies				
		ODC	Orthodontic	V	Vision				
		ODME	Other DME	VNSS	Vagus nerve stimulator surgery				
	I	. 1 ~ ~ ~ ~ ~ ~ ~							
		oos	Out of State	VOL	Inpatient admission-Voluntary				

3	Name: Required.	Enter the last name, first name, and middle initial of the patient you are requesting authorization for.
4	Client ID: Required.	<ul> <li>Enter the client ID = 9 numbers followed by WA.</li> <li>For Prior Authorization (PA) requests when the client ID is unknown (e.g. client eligibility pending):</li> <li>You will need to contact DSHS at 1-800-562-3022 and the appropriate extension of the Authorization Unit (See contact section for further instructions).</li> <li>A reference PA will be built with a placeholder client ID.</li> <li>If the PA is approved – once the client ID is known – you will need to contact DSHS either by fax or phone with the Client ID.</li> <li>The PA will be updated and you will be able to bill the services approved.</li> </ul>
5	Living Arrangements	Indicate where your patient resides such as, home, group home, assisted living, skilled nursing facility, etc.
6	Reference Auth #	If requesting a change or extension to an existing authorization, please indicate the number in this field.
7	Requesting NPI #: Required.	The 10 digit numeric number that has been assigned to the requesting provider by CMS.
8	Requesting Fax#	The fax number of the requesting provider.
9	Servicing NPI #: Required.	The 10 digit numeric number that has been assigned to the billing/servicing provider by CMS.
10	Name	The name of the billing/servicing provider.
11	Referring NPI #	The 10 digit numeric number that has been assigned to the referring provider by CMS.
12	Referring Fax #	The fax number of the referring provider.
13	Service Start Date	The date the service is planned to be started if known.
15	Description of service being requested: Required.	A short description of the service you are requesting (examples, manual wheelchair, eyeglasses, hearing aid).
18	Serial/NEA#: Required for all DME repairs.	Enter the serial number of the equipment you are requesting repairs or modifications to or the NEA# to access the x-rays for this request.
20	Code Qualifier: Required.	Enter the letter corresponding to the code from below:  T - CDT Proc Code C - CPT Proc Code D - DRG P - HCPCS Proc Code I - ICD-9/10 Proc Code R - Rev Code N - NDC-National Drug Code S - ICD-9/10 Diagnosis Code
21	National Code: Required.	Enter each service code of the item you are requesting authorization that correlates to the Code Qualifier entered.
22	Modifier	When appropriate enter a modifier.
23	# Units/Days Requested: Required.	Enter the number of units or days being requested for items that have a set allowable. (Refer to the program specific <u>Billing Instructions</u> for the appropriate unit/day designation for the service code entered).
24	\$ Amount Requested: Required.	Enter the dollar amount being requested for those service codes that do not have a set allowable. (Refer to the program specific <u>Billing Instructions</u> and <u>fee schedules</u> for assistance) Must be entered in dollars & cents with a decimal (e.g. \$400 should be entered as 400.00.
25	Part # (DME only): Required for all "By Report" codes requested.	Enter the manufacturer part # of the item requested.

26	Tooth or Quad#: Required for dental requests	Enter the tooth or quad number as listed below:  QUAD  00 – full mouth  01 – upper arch  02 – lower arch  10 – upper right quadrant  20 – upper left quadrant  30 – lower left quadrant  40 – lower right quadrant  Tooth # 1-36, A-T, AS-TS, 51-82 and SN
27	Diagnosis Code	Enter appropriate diagnosis code for condition.
28	Diagnosis name	Short description of the diagnosis.
29	Place of Service	Enter the appropriate two digit place of service code.
30	Comments	Enter any free form information you deem necessary.

Field	Name	Action				
		ALL FIELDS MUST BE TYPED				
	Org required	Enter the N	fumber that Matches the Program/Unit for the Request			
		500 - Divis	ion of Alcohol and Substance Abuse (DASA)			
		501 Denta	1			
		502 Dural	ole Medical Equipment (DME)			
	·	509 Econo	omic Services Administration (ESA) (DSHS)			
	•	504 - Home	<del>- Health</del>			
		505 - Ho	spice			
			ent-Hospital			
1		507 - Juvenile Rehabilitation Administration (JRA) (DSHS)				
		508 - Medi				
		509 - Med	ical Nutrition			
		510 - Men	tal Health			
			ot Proc/Diag			
		513 - Physi	cal Medicine & Rehabilitation (PM & R)			
			and Disability Services Administration (ADSA)			
		515 - Trans				
		516 - Misec	ellaneous			
	Service Type required	Enter the le	tter(s) in all CAPS that represent the service type you ar			
	Service Type required	requesting.	Enter the letter(s) in all CAPS that represent the service type you are			
		Toquostaig.				
		AA	Ambulatory Aids			
		BB	Bath Bench			
		BEM	Bath Equipment (misc)			
		BGM	Blood Glucose Monitors			
		BGS	Bone Growth Stimulator			
		BP	Breast Pumps			
		BS	Bariatric surgery			
		BSS2	Bariatric surgery stage 2			
		G CI	Cookley Implents			
		CIERP	Cochlear Implants Cochlear Implant Ext Repl Prts			
2		CSC	Commode/Shower Chair			
		CWN	Crowns			
		DASA	DASA			
		DEN	Dentures			
		EN	Enteral Nutrition			
		ESA	ESA			
		FSFS	Floor Sitter/Feeder Seat			
		HB	Hospital-Beds			
		HEA	Hearing Aids			
		HH	Home Health			
		HSPC	Hospice			
		<del>IPT</del>	Infusion/Parental Therapy			
	-	ITA	Inpatient admission—ITA			
		JRA	JRA			

- T			
Field	Name	Action	
		LTAC	LTAC
		MC	Medication
		MISC	Miscellaneous
		MN	Medical Nutrition
	,	MWH	Manual Wheelchair Home
		MWNF	Manual Wheelchair - NF
		θ	Other
		ODC	Orthodontic
		ODME	Other DME
		OOS	Out of State
		<del>OP</del>	Ostomy Products
		OS	Orthopedic Shoes
		OTC	Orthotics
		PAS	PAS
		PDN	Private Duty Nursing
		PHY	Pharmacy
		PL	Patient Lifts
		PMR	PM and R
	·	PROS	Prosthetics
		PRS	Prone Standers
			· · · · · · · · · · · · · · · · · · ·
		PSY	Psychotherapy
		PTL	Partial
		PWH	Power Wheelchair - Home
		PWNF	Power Wheelchair - NF
		PWNF	Power Wheelchair - NF
		PHYS	Physician Services
		R.	Respiratory
		RBS	Rebases
	•	RE	Room equipment
		RLNS	Relines
		RM	Readmission
		S	Surgery
		SBS	Specialty Beds/Surfaces
	,	SG	Shower chairs
		SCAN	MRI/PET Scans
		SF	Standing Frames
		SGD	Speech Generating Device
		SSIP	Short Stay (In-Patient)
		Ŧ	Therapies (PT/OT/ST)
		TRN	Transportation
		TU	TENS Units
		US	Urinary Supplies
		\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	Vision
		E .	
		VNSS	Vagus nerve stimulator surgery
		VOL	Inpatient admission Voluntary
-		WDCS	Wound/decubiti care supplies
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			ng authorization for.
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		For Prior Authorization (PA) requests when the client ID is unknown (e.g. client eligibility pending):  You will need to contact DSHS at 1-800-562-3022 and the appropriate extension of the Authorization Unit (See contact section for further instructions).  A reference PA will be built with a placeholder client ID.  If the PA is approved – once the client ID is known – you will need to contact DSHS either by fax or phone with the Client ID.  The PA will be updated and you will be able to bill the services approved.
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24	\$ Amount Requested: Required.	NOT REQUIRED FOR HOSPICE Enter the dollar amount being requested for those service codes that do not have a set allowable. (Refer to the program specific Billing Instructions and fee schedules

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-T-32 T T		
Field	Name	Action
		for assistance) Must be entered in dollars & cents with a decimal (e.g.
		\$400 should be entered as 400.00.
25	Part # (DME only): Required for	NOT REQUIRED FOR HOSPICE Enter the manufacturer part #
23	all "By Report" codes requested.	of the item requested:
	Tooth or Quad#: Required for	NOT REQUIRED FOR HOSPICE
	dental requests	Enter the tooth or quad number as listed below:
		QUAD
		00 full mouth
		01 upper arch
26		02 lower arch
26		10 upper right quadrant
	·	20 upper left quadrant
		30 lower left quadrant
		40 lower right quadrant
	·	Tooth # 1-36, A-T, AS-TS, 51-82 and SN
27	Diagnosis Code:	Enter appropriate diagnosis code for condition.
28	Diagnosis name	Short description of the diagnosis.
20	Place of Service	Enter the appropriate two digit place of service code.
29		Could use 12 OR 21 OR 31 OR 34
30	Comments:	Enter any free form information you deem necessary.

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